North Carolina Industrial Commission

IC File #_____

APPLICATION TO TERMINATE OR SUSPEND PAYMENT OF COMPENSATION (G.S. 97-18.1)

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN _____

Employee's Name	Employer's Name ( ) Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) ( ) Home Telephone Work Telephone	Carrier's Address City State Zip
☐ M ☐ F / / Social Security Number Sex Date of Birth	( ) ( ) Carrier's Telephone Number Fax Number

IMPORTANT NOTICE TO EMPLOYEE: YOUR BENEFITS MAY BE STOPPED UNLESS YOU OBJECT IMMEDIATELY. IF YOU BELIEVE YOUR BENEFITS SHOULD NOT BE STOPPED, YOU MUST FILL OUT SECTION B. OF THIS FORM AND RETURN ONE COPY OF THIS FORM TO THE INDUSTRIAL COMMISSION. IF THE INDUSTRIAL COMMISSION HAS NOT RECEIVED THE COMPLETED COPY OF THIS FORM FROM YOU BY_____, YOUR BENEFITS MAY BE STOPPED WITHOUT FURTHER NOTICE TO YOU. IF YOU OBJECT, YOU MAY HAVE THE RIGHT TO AN INFORMAL HEARING BY THE INDUSTRIAL COMMISSION BEFORE YOUR BENEFITS CAN BE STOPPED. (THE DATE TO BE INSERTED ABOVE BY THE EMPLOYER OR CARRIER/ADMINISTRATOR SHALL BE 17 DAYS AFTER THIS APPLICATION WAS MAILED TO THE INDUSTRIAL COMMISSION.)

SECTION A. **TO BE COMPLETED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR:**

1. Date of injury by accident : _____ Date disability began : _____
2. Nature and extent of injury: _____
3. Number of weeks compensation paid: _____ From : _____ To : _____
4. Total amount of indemnity compensation paid to date: $ _____
5. Check applicable box(s):
   - ☐ a. An agreement was approved by the Industrial Commission on _____
   - ☐ b. The employer admitted employee's right to compensation pursuant to N.C. Gen. Stat. § 97-18(b).
   - ☐ c. The employer paid compensation to employee without contesting claim within the statutory period provided under N.C. Gen. Stat. § 97-18(d).
   - ☐ d. Other: _____
6. Application is made to ☐ terminate or ☐ suspend compensation to the employee on the grounds that _____
7. ☐ Check box if employee is in managed care.

MAIL TO:
NCIC - EXECUTIVE SECRETARY
4333 MAIL SERVICE CENTER
RALEIGH, NC 27699-4333
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

FORM 24

In addition to filing the original of this application and supporting documents with the Industrial Commission, I hereby certify that a copy of this application, together with all supporting documents, was mailed to the employee at

(address)_____

_____

and employee's attorney of record, if any, on _____.
The attached documents consist of _____(number) pages.

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR | PRINTED NAME | TELEPHONE NUMBER | DATE

TO BE COMPLETED BY THE EMPLOYEE

SECTION B. IF YOU THINK YOUR COMPENSATION SHOULD NOT BE STOPPED, YOU SHOULD COMPLETE THIS SECTION.

1. I do not think my compensation should be stopped because: _____
   _____
   _____
   _____
2. Enclose and specify the number of pages of documents the Industrial Commission should consider: _____(number).
3. Give a telephone number at which you can be reached when the informal hearing is scheduled, from Monday through Friday between 8:00 a.m. and 5:00 p.m.:_____. The Industrial Commission will notify you of the date and time of the hearing.

SIGNATURE OF EMPLOYEE | WITNESS | DATE

If you need assistance in completing this form, you may contact the Industrial Commission at (800) 688-8349. You must contact the Office of the Executive Secretary at (919) 807-2500 to obtain an extension of time in which to submit medical records, or to obtain documents you have not been able to obtain.

EMPLOYEE: SEND A COPY OF THIS FORM AND SUPPORTING DOCUMENTS TO THE EMPLOYER AND CARRIER/ADMINISTRATOR **FROM WHOM YOU ARE RECEIVING COMPENSATION. SEND THE ORIGINAL TO: INDUSTRIAL COMMISSION, OFFICE OF THE EXECUTIVE SECRETARY, 4333 MAIL SERVICE CENTER, RALEIGH NC 27699-4333.**

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